United States Department of Labor
Employees' Compensation Appeals Board

C.G., Appellant	)	
and	)	**Docket No. 17-1142**
	)	**Issued: January 25, 2018**
U.S. POSTAL SERVICE, POST OFFICE, Chicago, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On March 31, 2017 appellant filed a timely appeal from December 21, 2016 and February 8, 2017 merit decisions of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether OWCP properly terminated appellant's wage-loss compensation and medical benefits, effective November 22, 2016, as she forfeited her entitlement to compensation pursuant to 5 U.S.C. § 8148(a); and (2) whether appellant has established more than two percent permanent impairment of the left lower extremity, for which she previously received a schedule award.

[1] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

On December 29, 2010 appellant, then a 38-year-old city carrier, filed an occupational disease claim (Form CA-2) alleging left foot and ankle pain as a result of constant standing and walking on a concrete floor while in the performance of duty. She first became aware of her condition and realized it resulted from factors of her federal employment on December 22, 2010. Appellant stopped work on December 22, 2010 and returned to modified duty on December 28, 2010.

OWCP accepted her claim for left foot tarsal tunnel syndrome.

On April 23, 2011 appellant stopped work because no work was available. She filed various claims for wage-loss compensation (Form CA-7) for intermittent periods of disability. OWCP paid intermittent wage-loss compensation on the supplemental rolls from December 22, 2010 until September 24, 2012.

On July 10, 2012 appellant filed a claim for a schedule award (Form CA-7).

In a letter dated July 20, 2012, OWCP advised appellant that, for a schedule award claim, the medical evidence of record must demonstrate that her accepted condition had reached a permanent and fixed state, known as maximum medical improvement (MMI). It informed appellant that no additional action could be taken on her schedule award claim until she submitted supporting medical evidence which demonstrated that she had reached MMI.

By letter dated August 25, 2013, appellant requested that OWCP reopen her request for a schedule award. She indicated that she was enclosing up-to-date documentation of her foot and ankle injury, which also showed that her condition had reached MMI.

In a September 26, 2013 report, Dr. Samuel J. Chmell, a Board-certified orthopedic surgeon, indicated that he reexamined and reevaluated appellant and noted that she was at MMI for her left foot and ankle. He reported that appellant had objective indication of impairment at her left ankle and foot.

On March 12, 2014 appellant filed another claim for a schedule award (Form CA-7).

In a March 30, 2014 report, Dr. Christopher Gross, an OWCP medical adviser, indicated that he had reviewed appellant's medical records for determination of permanent impairment under the sixth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*)[2] and MMI for her accepted condition of left foot tarsal tunnel syndrome. He noted that appellant underwent left tarsal tunnel release surgery on August 18, 2011. Dr. Gross reported that he could not provide an impairment rating for appellant's left foot condition without an examination or discussion about appellant's functional status. He requested appellant's most recent examination report in order to proceed.

OWCP advised appellant, by letter dated May 12, 2014, that the evidence submitted was insufficient to support her schedule award claim. It requested that she provide a medical report

[2] A.M.A., *Guides* (6th ed. 2009).

from her treating physician with an opinion on whether she had reached MMI and whether she had a permanent impairment rating utilizing the sixth edition of the A.M.A., *Guides*. Appellant was afforded 30 days to submit the additional evidence.

In a May 24, 2014 report, Dr. Chmell noted that appellant had reached MMI with regard to her accepted left tarsal tunnel syndrome as of May 8, 2014. He reported examination findings of markedly diminished sensation and grade 3 motor strength in the tibial sensory nerve distribution at appellant's left ankle and foot. Tinel's sign was positive in the area of the tarsal tunnel. Dr. Chmell noted that appellant had not undergone surgery for this condition. He explained that according to the sixth edition of the A.M.A., *Guides*, Table 16-12, for peripheral nerve impairments in the lower extremity, appellant was a class 2 for a moderate problem due to her moderate motor deficit. Dr. Chmell related that according to Table 16-11, appellant had moderate severity in terms of her sensory and motor deficit with a markedly diminished sensory exam and grade 3 strength/weakness. He indicated that appellant's adjustment for the severity class provided a default classification of 14 percent permanent impairment. Dr. Chmell concluded that appellant had 14 percent permanent impairment to her left lower extremity. He included a worksheet of its calculations.

Dr. Michael Hellman, an OWCP medical adviser, reviewed Dr. Chmell's May 24, 2014 report and disagreed with his impairment rating. In a September 10, 2014 report, he opined that appellant did not have a severity 2 motor deficit and noted that a left foot electromyography (EMG) report showed a preserved tibial motor branch. Dr. Hellman indicated that according to Table 16-11, appellant had moderate sensory severity due to her slightly decreased sensation. He further noted that under Table 16-12, appellant was a class 1, grade C, with a default value of two percent for sensory tibial nerve impairment. Dr. Hellman reported that appellant had grade modifiers of one for functional history due to complaints of heel pain, one for physical examination, and one for clinical studies. He applied the net adjustment formula and calculated that appellant had two percent permanent impairment of the left lower extremity.

OWCP granted appellant a schedule award for two percent permanent impairment of the left lower extremity in a November 21, 2014 decision. The award ran from August 15 to September 24, 2012.

On December 15, 2014 OWCP received appellant's request for an oral hearing before a representative of OWCP's Branch of Hearings and Review. A hearing was held on July 17, 2015. Appellant alleged that the date of MMI, the period of award, and the amount of award covered in the schedule award were wrong. She noted that she would submit additional information regarding her schedule award claim.

OWCP received a December 15, 2014 report by Dr. Chmell. Dr. Chmell disagreed with OWCP's impairment rating of two percent permanent impairment. He contended that he provided a well-rationalized determination based upon the A.M.A., *Guides* that appellant had 14 percent permanent impairment of her left lower extremity. Dr. Chmell concluded that OWCP's award of two percent permanent impairment was arbitrary and unethical.

By decision dated October 5, 2015, an OWCP hearing representative affirmed the November 21, 2014 schedule award decision. He determined that the medical evidence of record failed to establish that appellant was entitled to an increased schedule award.

On April 5, 2016 appellant requested reconsideration.

OWCP received an October 29, 2015 report from Dr. Chmell. Dr. Chmell clarified that he had performed surgery on appellant's right hand and wrist, which was not related to appellant's left leg condition. He also noted that a number of years had elapsed since Dr. Robert Fink, an orthopedic surgeon, had evaluated appellant and explained that neurological symptoms, such as motor deficits, worsened over time. Dr. Chmell alleged that his May 8, 2014 note clearly documented a serious motor deficit involving appellant's left tibial nerve.

OWCP referred appellant's claim, along with a statement of accepted facts (SOAF) and the record, to Dr. Jovito Estaris, a Board-certified orthopedic surgeon and OWCP medical adviser, in order to determine whether appellant sustained more than two percent permanent impairment of her left lower extremity as a result of her employment injury. In a July 24, 2016 report, Dr. Estaris indicated that Dr. Chmell did not provide any detailed measurement of the strength of appellant's involved muscle groups nor show any objective measurements like point discrimination or Semmes-Weinstein tests. He recommended a second opinion examination due to the "inadequate data."

Appellant underwent electromyography and nerve conduction velocity (EMG/NCV) testing with Dr. Chmell. In an October 11, 2016 report, Dr. Chmell noted left S1 sensory compression irritation leading to demyelination at the left ankle joint, bilateral L4 active radiculopathy sensory/motor, right and L4-5 radiculopathy mainly affecting the tibial nerve motor fibers.

OWCP referred appellant's claim to Dr. James Elmes, a Board-certified orthopedic surgeon, for a second opinion examination. In an October 13, 2016 report, Dr. Elmes, reviewed appellant's history, including the SOAF, and discussed the medical treatment appellant received for her accepted left foot condition. He reviewed appellant's medical records and noted his disagreement with Dr. Chmell's impairment rating of 14 percent for the left lower extremity. Dr. Elmes related appellant's current complaints of persistent left ankle and foot pain. Upon physical examination, he reported normal heel and toe gait pattern with no limp. Dr. Elmes further noted appellant's complaints of mild left ankle pain with walking and mild left ankle discomfort with heel and toe walking. Motor examination showed 5/5 strength of the bilateral lower extremities. Dr. Elmes indicated that neurological examination of appellant's lower extremities showed decreased sensation in the left lateral foot to light touch. He provided range of motion findings. Dr. Elmes reported diagnoses of left tarsal tunnel syndrome, right L5-S1 radiculopathy, bilateral carpal tunnel syndrome, and bilateral cubital tunnel syndrome.

Referring to Table 16-11 for sensory and motor severity and Table 16-12 for tibial nerve impairment of the sixth edition of the A.M.A., *Guides*, Dr. Elmes reported that appellant had two percent permanent impairment for left tarsal tunnel syndrome. He noted that appellant had a class 1 for mild problem, with a default value of two percent impairment. Dr. Elmes related grade modifiers of one for functional history and noted no grade modifiers for physical examination and clinical studies. He applied the net adjustment formula, which resulted in zero adjustment, for a result of two percent permanent impairment of the left lower extremity.

By decision dated December 21, 2016, OWCP determined that appellant had forfeited her entitlement to compensation beginning November 22, 2016. It noted that she had pled guilty to

defrauding the FECA program and accepted a plea agreement for one count of theft of government funds. OWCP explained, that as a result of her conviction and in accordance with 5 U.S.C. § 8148(a) and 20 C.F.R. § 10.17, appellant's compensation benefits, including schedule award benefits, had been terminated effective November 22, 2016 and that she was not entitled to receive further benefits under FECA. Appellant was informed that OWCP would pay for any authorized medical treatment appellant received prior to the date of the conviction, but no further medical treatment would be paid beyond that date.

In a December 25, 2016 report, Dr. Estaris, an OWCP medical adviser, reviewed Dr. Elmes's October 13, 2016 second opinion report and SOAF and noted appellant's accepted condition of left tarsal tunnel syndrome. He reported a date of MMI of October 13, 2016 and referenced Table 16-12 and assigned a diagnosis of tarsal tunnel syndrome. Dr. Estaris indicated grade modifiers of one for functional history and physical examination and no grade modifiers for clinical studies, which resulted in zero adjustment after applying the net adjustment formula. He concluded that appellant had two percent permanent impairment of the left lower extremity. Dr. Estaris further discussed that under an alternative method for rating tarsal tunnel syndrome using Table 15-23, appellant also had two percent permanent impairment of the left lower extremity.

By decision dated February 8, 2017, OWCP denied modification of the November 21, 2014 schedule award decision. It found that the medical evidence of record was insufficient to establish that appellant was entitled to more than two percent permanent left lower extremity impairment, for which appellant previously received a schedule award.

LEGAL PRECEDENT -- ISSUE 1

Section 8148(a) of FECA provides for the termination of benefits payable to beneficiaries who have been convicted of defrauding the program.[3] It specifically provides that any individual convicted of a violation of 18 U.S.C. § 1920 or any other federal or state criminal statute relating to fraud in the application for or receipt of any benefit under FECA, shall forfeit, as of the date of such conviction, any entitlement to any benefit to which such individual would otherwise be entitled under FECA for any injury occurring on or before the date of such conviction.[4] Such forfeiture shall be in addition to any action the Secretary may take under section 8106[5] (forfeiture) or section 8129[6] (recovery of overpayment of FECA).[7]

Section 10.7 of OWCP's implementing regulations provides that, when a claimant pleads guilty to federal or state criminal charges of fraud in connection with receipt of Federal Government benefits, the claimant's entitlement to further compensation benefits will terminate

[3] 5 U.S.C. § 8148(a).

[4] *Id.*

[5] 5 U.S.C. § 8106.

[6] *Id.* at § 8129.

[7] *Id.* at § 8148; *see F.C.*, 59 ECAB 666 (2007).

effective the date the guilty plea is accepted. Termination of entitlement under this section is not affected by any subsequent change in or recurrence of the beneficiary's medical condition.[8]

OWCP's procedures provide that in support of termination or suspension of compensation the record must contain copies of the indictment or formal accusation that that the person has committed the crime, the plea agreement, if any, the document containing the guilty verdict and/or the court's docket sheet. Further, this evidence must establish that the individual was convicted and the conviction is related to the claim for or receipt of the compensation benefits under FECA.[9] The termination is effective on the date of the verdict or on the date the guilty plea is accepted and guilt adjudicated.[10] Because of the criminal basis for the termination, no pretermination notice is required before a final decision is issued.[11]

ANALYSIS -- ISSUE 1

The Board finds that OWCP improperly terminated appellant's compensation benefits effective November 22, 2016.

OWCP procedures provide that to support the termination or suspension of compensation under 5 U.S.C. § 8148, the evidence of record must contain copies of the indictment or formal accusation that the person has committed the crime, the plea agreement, if any, the document containing the guilty verdict, and/or the court's docket sheet.[12] In this case, the evidence of record does not contain copies of the indictment, plea agreement, or court judgment. According to OWCP's December 21, 2016 decision, on November 22, 2016, appellant had accepted a plea agreement of guilty to one count of theft of government funds. However, the case record does not contain a copy of a plea agreement or other court document noting a guilty plea or conviction upon which to base the forfeiture of compensation. The Board therefore finds that OWCP did not properly terminate appellant's compensation and schedule award benefits.[13] The December 21, 2016 decision terminating appellant's compensation and schedule award benefits effective November 22, 2016, shall therefore be reversed.

LEGAL PRECEDENT -- ISSUE 2

The schedule award provisions of FECA[14] and its implementing regulations[15] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. FECA, however, does

[8] 20 C.F.R. § 10.17.

[9] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Disallowances*, Chapter 2.1400.17c(2) (February 2013).

[10] *Id.* at Chapter 2.1400 17(d) (February 2013).

[11] *Id.* at Chapter 2.1400.4(a)(6) (February 2013).

[12] *Supra* note 8.

[13] *See Lorenzo P. Garcia*, Docket No. 99-1665 (issued July 12, 2001).

[14] 5 U.S.C. § 8107.

[15] 20 C.F.R. § 10.404.

not specify the manner in which the percentage of loss of a member shall be determined. The method used in making such determination is a matter which rests in the sound discretion of OWCP. For consistent results and to ensure equal justice, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by OWCP as a standard for evaluation of schedule losses and the Board has concurred in such adoption.[16] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition of the A.M.A., *Guides*, published in 2009.[17]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability and Health (ICF).[18] Under the sixth edition, the evaluator identifies the impairment for the diagnosed condition Class of Diagnosis (CDX), which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE), and Clinical Studies (GMCS). The net adjustment formula is (GMFH - CDX) + (GMPE - CDX) + (GMCS - CDX).[19] Evaluators are directed to provide reasons for their impairment rating choices, including the choices of diagnosis from regional grids and calculations of modifier scores.[20]

Section 8123(a) of FECA provides that, if there is a disagreement between the physician making the examination for the United States and the physician of an employee, the Secretary shall appoint a third physician (known as a referee physician or impartial medical specialist) who shall make an examination.[21] This is called a referee examination and OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[22]

ANALYSIS -- ISSUE 2

OWCP accepted appellant's occupational disease claim for left tarsal tunnel syndrome. Appellant filed a claim for a schedule award. OWCP granted appellant a schedule award for two percent permanent impairment of the left lower extremity as a result of her accepted left foot condition in a November 21, 2014 decision. Appellant disagreed with the schedule award and filed requests for an oral hearing and reconsideration. She continued to submit reports by Dr. Chmell, her treating physician, who had opined in a May 24, 2014 report that appellant had reached MMI, and had 14 percent permanent impairment of the left lower extremity according to

[16] *Id*.; *see also Jacqueline S. Harris*, 54 ECAB 139 (2002).

[17] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.806.6.6a (January 2010); Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700.2 and Exhibit 1 (January 2010).

[18] A.M.A., *Guides* (6th ed. 2009), p3, section 1.3.

[19] *Id.* at 494-531.

[20] *See R.V.*, Docket No. 10-1827 (issued April 1, 2011).

[21] 5 U.S.C. § 8123(a); *see R.S.*, Docket No. 10-1704 (issued May 13, 2011); *S.T.*, Docket No. 08-1675 (issued May 4, 2009).

[22] 20 C.F.R. § 10.321.

the sixth edition of the A.M.A., *Guides*. Dr. Elmes, an OWCP second opinion examiner, and Dr. Estaris, an OWCP medical adviser, disagreed with Dr. Chmell's impairment rating and in reports dated October 13, 2016 and December 25, 2016 determined that appellant had two percent permanent impairment of the left lower extremity. Based on Dr. Estaris' report, OWCP found that appellant was not entitled to more than two percent permanent impairment of the left lower extremity, for which she previously received a schedule award.

The Board finds that this case is not in posture for decision as there is an unresolved conflict in medical opinion regarding whether appellant has more than two percent impairment of the left lower extremity, for which she previously received a schedule award.

In a May 24, 2014 report, Dr. Chmell noted examination findings of markedly diminished sensation and grade 3 motor strength in the tibial sensory nerve distribution at appellant's left ankle and foot. He explained that according to Table 16-12 of the sixth edition of the A.M.A., *Guides* appellant was a class 2 for moderate motor deficit. Dr. Chmell indicated that according to Table 16-11 appellant had default 14 percent permanent impairment for moderate severity of sensory and motor deficit. In his October 29, 2015 report, he related that appellant's conditions had worsened. In his October 11, 2016 report, Dr. Chmell related sensory and motor findings based upon EMG/NCV studies.

OWCP referred Dr. Chmell's report to Dr. Elmes, a second opinion examiner, who disagreed with Dr. Chmell's impairment rating. Dr. Elmes explained that, although Dr. Chmell noted moderate severity of sensory deficit, he observed no anatomic numbness of appellant's left lower extremity on physical examination. He referenced Table 16-11 and Table 16-12 of the sixth edition of the A.M.A., *Guides* and concluded that appellant had two percent permanent impairment of her left lower extremity. In a December 25, 2016 report, Dr. Estaris, an OWCP medical adviser, reviewed Dr. Elmes' report and agreed with his impairment rating. Accordingly, he concluded that appellant had two percent permanent impairment of the left lower extremity and was not entitled to any additional award.

The Board finds that there is an unresolved conflict in the medical evidence between Dr. Chmell, appellant's treating physician, and Dr. Elmes and Dr. Estaris, OWCP's physicians, regarding whether appellant has more than two percent permanent impairment of her left lower extremity as a result of her accepted left foot condition.[23]

As noted above, if there is a disagreement between an employee's physician and OWCP's referral physician, OWCP will appoint a referee physician or impartial medical specialist who shall make an examination.[24] As there is an unresolved conflict in the medical evidence regarding whether appellant has established more than two percent permanent impairment of her left lower extremity, the case must be remanded to OWCP for referral to an impartial medical specialist for resolution of the conflict in the medical opinion evidence in accordance with 5 U.S.C. § 8123(a). After such further development as OWCP deems necessary, it shall issue a *de novo* decision.

[23] *See G.W.*, Docket No. 17-957 (issued June 19, 2017).

[24] *Supra* note 19.

CONCLUSION

The Board finds that OWCP improperly terminated appellant's compensation benefits pursuant to 5 U.S.C. § 8148(a), effective November 22, 2016. The Board also finds that the case is not in posture for decision regarding whether appellant has more than two percent permanent impairment of her left lower extremity, for which she previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the December 21, 2016 decision of the Office of Workers' Compensation Programs is reversed. The February 8, 2017 decision of the Office of Workers' Compensation Programs is set aside and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: January 25, 2018
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board